STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	366202	a. building _____ b. wing _____	**03/27/2019**

name of provider or supplier	street address, city, state, zip code
CRYSTAL CARE OF COAL GROVE	**813 1/2 MARION PIKE COAL GROVE OH, 45638**

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F 0000	INITIAL COMMENTS COMPLAINT INVESTIGATION MASTER COMPLAINT NUMBER OH00103375 COMPLAINT NUMBER OH00103138 COMPLAINT NUMBER OH00101649 ADMINISTRATOR: Tara Givens, #6862 CERTIFIED BED CAPACITY: 57 CENSUS: 49 MEDICARE: 3 MEDICAID: 43 OTHER: 3 The following deficiencies are based on the complaint investigation completed on 03/27/19.	F 0000		

laboratory director's or provider/supplier representative's signature | title | (x6) date

TARA.GIVENS | 04/30/2019

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. for nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. if deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0583	Continued From page 1	F 0583		
F 0583 SS=D	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care	F 0583	The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation or compliance. All alleged deficiencies have been or are to be corrected by 5/1/2019, the center's alleged date of compliance. Resident number 9 was assessed by the DON for negative outcomes related to deficiency number F583 on 3/25/2019, and no negative outcomes were noted. Nursing staff was educated via in-service by the ADON on 3/29/2019 on the policy on privacy and confidentiality (HIPAA). The ADON or designee will audit medication and treatment records for maintaining resident's confidentiality 3 times a week for 4 weeks and 1 time a month for 3 months. The QA committee will review the monitoring tables to determine the need to continue, change or if compliance has been achieved. Employee number 105 received a written education by the ADON related to deficiency number F583 on privacy and confidentiality on 3/28/2019	05/01/2019

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F 0583	Continued From page 2 Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to maintain Resident #9's medication administration record (MAR) in a confidential manner. This affected one resident (Resident #9) of 19 residents whose administration records were contained in the book on the medication cart. Findings Include: On 03/25/19 from 10:38 A.M. to 10:43 A.M. the medication administration record was observed lying open on top of the medication cart in the hallway. No staff were observed at the cart and the administration record for Resident #9 was observed to be visible. An interview with Resident #42, who was observed in the hallway where the medication cart was located revealed she thought the nurse had gone back into the office and was on the telephone. On 03/25/19 at 10:43 A.M. observation and interview with the Director of Nursing (DON) confirmed the medication administration record was open on top of the medication cart located in the hallway and in full view of residents and/or visitors.	F 0583		

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F 0583	Continued From page 3 Review of the policy titled, Resident Rights dated 09/01/18 indicated the facility must protect and promote the rights of each resident including privacy and confidentiality. This deficiency is an incidental finding to Complaint Number OH00103138.	F 0583		

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F 0677	Continued From page 4	F 0677		
F 0677 SS=E	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure Resident #20, Resident #36, Resident #41 and Resident #50, who required staff assistance for activities of daily living received timely and adequate showers as planned to promote optimal hygiene. This affected four residents (Resident #20, #36, #41 and #50) of four residents reviewed for activities of daily living. Findings Include: 1. Record review revealed Resident #36 was admitted to the facility on 02/13/19 with diagnoses including chronic obstructive pulmonary disease, peripheral disease, hypertension, history of amputation and anxiety. Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 02/20/19 revealed the resident had intact cognition. The MDS 3.0 indicated Resident #36 was totally dependent with one person physical assist for bed mobility, transfers and toilet use and	F 0677	The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation or compliance. All alleged deficiencies have been or are to be corrected by 5/1/2019, the center's alleged date of compliance. On 3/28/2019 DON assessed resident number 20, 36, 41, and 50 for negative outcomes related to deficiency number F677, and no negative outcomes were noted. A staff in-service was completed on 3/28/2019 by the ADON related to deficiency number F677, and the shower policy was reviewed with the staff. The ADON or designated employee will interview 10 residents 1 time a week for 4 weeks then 1 time month for 3 months to ensure residents are receiving showers per their preference. The QA committee will review the monitoring tables to determine the need to continue, change or if compliance has been achieved.	05/01/2019

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F 0677	Continued From page 5 required extensive assistance from one person for locomotion on and off the unit, dressing and personal hygiene. The plan of care identified Resident #36 was at risk for decline in activity of daily living performance/participation related to diagnoses. Interventions included preventative skin care as needed and monitor for skin breakdown, provide peri-care with each incontinent episode as needed, report declines to physician, and turn and reposition as needed. There was no evidence or plan in place to reflect the resident refused showers. Review of the facility shower schedule indicated Resident #36 was to receive a shower three times per week. Review of the shower documentation revealed the resident only received one shower the week of 02/18/19 and two showers the week of 02/25/19, 03/04/19 and 03/11/19. The documentation revealed no evidence the resident refused showers during this time period. On 03/27/19 at 2:10 P.M. interview with the Director of Nursing (DON) verified the lack of evidence to indicate Resident #36 was receiving three showers per week as scheduled. The DON reported the facility current documentation of bathing was recorded in three separate places and stated the documentation was not always	F 0677		

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F 0677	Continued From page 6	F 0677		

completed. The DON confirmed any shower that was not completed on the assigned shift should be reported to the nurse and the following shift STNA for completion.

Review of facility policy titled Shower Policy, dated 12/01/18 revealed the residents should receive at least two showers per week and the facility would make all reasonable attempts to accommodate extra shower requests.

2. Record review revealed Resident #50 was admitted to the facility on 11/13/18 with diagnoses including paraplegia, sepsis, depression, anxiety and hypertension. Review of the significant change Minimum Data Set (MDS) 3.0 assessment, completed on 01/22/19 indicated Resident #50 had moderately impaired cognition and was totally dependent on staff for all activities of daily living.

Review of the plan of care for Resident #50 identified the resident was at risk for a decline in function with a goal for the resident's activities of daily living to be met with interventions including to make activities of daily living consistent to foster tasks.

The State Tested Nursing Assistant (STNA) tracking form indicated Resident #50 required extensive assistance of one

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F 0677	Continued From page 7 person for bathing. The tracking form indicated Resident #50 received eleven bed baths and three showers from 03/01/19 through 03/14/19. There was no documentation of Resident #50 receiving any type of bath or shower since 03/14/19. There were no shower sheets completed for Resident #50 available for review during the onsite investigation. Review of the bathing schedule for Resident #50 revealed the resident was scheduled to be bathed on evening shifts on Monday, Wednesday, and Friday. During an interview on 03/25/19 at 11:10 A.M. Resident #50 reported he was supposed to get a shower three times a week, however he had not had a shower for the past week. Resident #50 stated it depended on what STNA staff were working as to whether he received a shower or not. Resident #50 stated he did not consider staff offering a wash cloth for his face and providing care after incontinence a bed bath, however some STNAs thought it was. During the interview, Resident #50 reported would like to have more showers. During an interview on 03/26/19 at 5:27 A.M. with STNA #145, the STNA reported she did not normally work the front hall, however due to a call off, she had floated from the back hall to the front hall and was not as familiar with the residents on the	F 0677		

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F 0677	Continued From page 8 front hall. STNA #145 reported Resident #50 had not received a shower on her shift and was not sure when he was scheduled, however the STNA stated the resident had not asked to be showered. STNA #145 confirmed that no shower had been offered to Resident #50 on 03/25/19 as planned. On 03/27/19 at 2:10 P.M. the DON confirmed there was no evidence Resident #50 had been offered a shower or bed bath since 03/14/19. Review of facility policy titled, Shower Policy, dated 12/01/18 revealed the residents should receive at least two showers per week and facility would make all reasonable attempts to accommodate extra shower requests. 3. Record review revealed Resident #20 was admitted to the facility on 10/23/17 with diagnoses including alcohol induced dementia, inhalant induced psychotic disorder, anxiety, visual hallucinations, pseudobulbar affect, and depression. Review of the annual MDS 3.0 assessment, completed on 11/05/18 indicated the resident was unable to be understood and required extensive assistance from staff for all activities of daily living. Review of the shower schedule revealed Resident #20 was to receive a shower every Tuesday, Thursday and Saturday.	F 0677		

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F 0677	Continued From page 9 Review of the STNA tracking form revealed no evidence the resident received a shower or bath between 03/11/19 and 03/26/19. During an interview with STNA #121 on 03/26/19 at 5:19 A.M., the STNA reported she had showered Resident #20 that evening. When the surveyor asked why Resident #20 had same clothes on after her shower as what the resident was observed wearing on 03/25/19, the STNA did not reply. STNA #121 then indicated a shower schedule was located at the nurse's station, however she did not check the shower schedule to see which residents were to be showered on her shift. On 03/27/19 at 2:10 P.M. the DON confirmed there was no evidence to support Resident #20 had received a shower or bath between 03/11/19 and 03/26/19. Review of facility policy titled Shower Policy, dated 12/01/18 revealed the residents should receive at least two showers per week and facility would make all reasonable attempts to accommodate extra shower requests. 4. Record review revealed Resident #41 was admitted to the facility on 12/21/18 with diagnoses including epilepsy, unspecified psychoses and protein-calorie malnutrition. Review of the admission	F 0677		

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F 0677	Continued From page 10 MDS 3.0 assessment, completed on 12/28/18 revealed Resident #41 was totally dependent on staff for bathing. Review of the shower schedule indicated Resident #41 was to receive a shower on 03/25/19 during the evening/night shift. However, review of the STNA tracking documentation revealed Resident #41 did not receive a shower on 03/25/19. During an interview with STNA #121 on 03/26/19 at 5:19 A.M. the STNA reported she did not provide Resident #41 a shower or bath on her shift. At the time of the interview, STNA #121 confirmed Resident #41 was on the schedule to receive a shower on 03/25/19. However, the STNA reported she had not checked the shower schedule to see which residents were to be showered on her shift. On 03/27/19 at 2:10 P.M. the DON confirmed there was no evidence Resident #41 had received a shower on 03/25/19 as planned. Review of facility policy titled Shower Policy, dated 12/01/18 revealed the residents should receive at least two showers per week and facility would make all reasonable attempts to accommodate extra shower requests. This deficiency substantiates Complaint Number OH00103138.	F 0677		

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F 0680 SS=C	483.24(c)(2)(i)(ii)(A)-(D) Qualifications of Activity Professional §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure the activities program was directed by a qualified professional as required. This had the potential to affect all 49 residents residing in the facility. Findings Include: On 03/27/19 at 11:15 A.M. interview with Activity Director (AD) #108 revealed she accepted the Activity Director position on 01/04/19, however she reported she had no	F 0680	The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation or compliance. All alleged deficiencies have been or are to be corrected by 5/1/2019, the center's alleged date of compliance. Certified activity director from sister facility will provide oversight for Activities until a qualified activity director is hired. Facility has posted an ad immediately for qualified activity director. Resident's were interviewed concerning their activity likes and needs. Administrator or designee will interview 5 residents a week times 4 weeks then 1 time monthly for 3 months to verify activities are meeting their needs. The QA committee will review the monitoring tables to determine the need to continue, change or if compliance has been achieved.	05/01/2019

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F 0680	Continued From page 12 type of training for this position. AD #108 reported she did not know she was required to be trained for the position of Activity Director. Review of AD #108's personal file revealed a hire date of 01/04/19 for the position of Activity Director. There was no evidence of any type of license, certification, past experience or completion of an approved training course by the State located in the personal file. There was no evidence AD #108 was a qualified therapeutic recreation specialist or an activities professional who was licensed or registered, if applicable, by the State in which practicing. In addition, there was no evidence AD #108 was eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990, had two years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program, was a qualified occupational therapist or occupational therapy assistant or had completed a training course approved by the State. On 03/27/19 at 3:04 P.M. interview with the Administrator revealed the facility was in the process of assisting AD #108 to obtain the necessary qualifications to be	F 0680		

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F 0680	Continued From page 13 the facility activity director. The Administrator verified AD #108 did not meet the current qualification requirements to hold the position. This deficiency is an incidental finding to Complaint Number OH00101649.	F 0680		

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F 0727	Continued From page 14	F 0727		
F 0727 SS=C	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to use the services of a registered nurse for at least eight consecutive hours a day, seven days per week as required. This had the potential to affect all 49 residents residing in the facility. Findings Include: Review of staffing schedule and time cards for 03/23/19 through 03/24/19 revealed on 03/23/19 and on 03/24/19 a RN was not available for eight consecutive hours. Record review revealed an RN was on duty	F 0727	The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation or compliance. All alleged deficiencies have been or are to be corrected by 5/1/2019, the center's alleged date of compliance. After the survey completion on 3/27/2019, the administrator educated the DON, ADON, and scheduler on requirements for RN coverage on duty 8 hours a day, 7 days a week. After completion of the survey on 3/27/2019, residents were assessed and there were no negative effects. The ADON or designee will audit registered nurse coverage 7 times a day for four weeks then 1 time a month for 3 months thereafter. The QA committee will review the monitoring tables to determine the need to continue, change or if compliance has been achieved.	05/01/2019

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F 0727	Continued From page 15 for only four hours on each of these days. On 03/26/19 at 1:54 P.M. interview with the director of nursing (DON) confirmed the facility did not provide eight hours of RN coverage on 03/23/19 or 03/24/19 as RN #124 only worked four hours on each of those days. This deficiency substantiates Complaint Number OH00103138.	F 0727		

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F 0761	Continued From page 16	F 0761		
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure	F 0761	The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation or compliance. All alleged deficiencies have been or are to be corrected by 5/1/2019, the center's alleged date of compliance. Resident number 9 and 42 were assessed by the DON for negative outcomes related to deficiency F761, of properly storing drugs on 3/25/2019, and no negative outcomes were noted. Nursing staff was educated via in-service on 3/29/2019 by the ADON on the policy on label/store drugs and biologicals relating to deficiency F761. The ADON or designee will monitor all the medications carts to ensure labeling/storage of drugs and biologicals are being carried out effectively related to deficiency F761. The monitoring will be completed by the DON or designated employee for 3 times a week for 4 weeks then 1 time a month for 3 months thereafter. The QA committee will review the monitoring tables to determine the need to continue, change or if compliance has been achieved.	05/01/2019

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F 0761	Continued From page 17 Resident #9's medications were properly stored. This affected one resident (Resident #9) of 19 residents whose medications were observed to be stored on the medication cart. Findings Include: On 03/25/19 at 10:38 A.M. as the surveyor entered the facility, a medication cart was observed unlocked in the hall. There were no staff observed at the cart or in the general vicinity/view of the cart. There were four pills observed in sealed packets on top of the cart and one pill observed in a medicine cup unattended on the cart at the time of the observation. Interview with Resident #42, who was sitting in her wheelchair adjacent to the cart revealed she thought the nurse had left the cart and gone to the nurse's station to take a phone call. On 03/25/19 at 10:43 A.M. interview with the director of nursing (DON) confirmed the medication cart was unlocked, unattended by nursing staff and had medication unsecured on top of the cart. The DON revealed she was not aware where the nurse was who was administering medication. At that time, Resident #42 repeated she thought the nurse was at the nurse's station on the phone. The DON indicated there were three Baclofen 10 milligrams (mg) tablets and one Atorvastatin Calcium 40 mg tablet on top	F 0761	Employee number 105 received a written education by the ADON related to deficiency number F761 relating to labeling/storing drugs and biologicals on 3/28/2019.	

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F 0761	Continued From page 18 of the cart in individual wrappers and one unidentified tablet was in the medication cup. On 03/25/19 at 11:38 A.M. interview with Licensed Practical Nurse (LPN) #105 confirmed she had left the medication cart unlocked with medications on top of the cart. LPN #105 reported she had a phone call and had forgot to secure the medications before leaving the cart. LPN #105 reported the medications were to be administered to Resident #9. Review of the facility undated Medication Storage policy revealed medications were to be securely stored. This deficiency is an incidental finding to Complaint Number OH00103138.	F 0761		

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F 0921	Continued From page 19	F 0921		
F 0921 SS=F	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the environment was maintained in a sanitary, functional, safe and comfortable manner for all residents. This affected 14 residents (Resident #1, #3, #4, #15, #17, #19, #22, #24, #26, #29, #39, #40, #41 and #43) and had the potential to affect all 49 residents residing in the facility residents who had access to the common areas within the facility. Findings Include: 1. On 03/25/19 from 11:00 A.M. to 11:40 A.M. a tour of the facility revealed a strong urine odor was noted outside Resident #41's room. Upon entering the room, Resident #41 was observed to have a gel mattress with a blue covering on the bed. No sheets were on Resident #41's mattress and brown areas were observed on the blue mattress covering. State Tested Nursing Assistant (STNA) # 120 confirmed the findings at the time of the observation and indicated Resident #41 was incontinent of urine and bowel. STNA	F 0921	The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation or compliance. All alleged deficiencies have been or are to be corrected by 5/1/2019, the center's alleged date of compliance. DON assessed the following residents: 1, 3, 4, 15, 17, 19, 22, 24, 26, 29, 39, 40, 41, and 43 for negative outcomes related to deficiency number F921 on 3/27/2019 and no negative outcomes were noted. Resident number 41 was assessed related to deficiency number F921 on 3/25/2019 by the DON, and no negative outcomes were noted. The facility replaced mattress from resident's room with a new mattress on 3/27/2019. Resident number 41 was placed on toileting plan, after an order was obtained, staff was in-serviced, and the care plan was updated, and carried out by the ADON on 3/27/2019. Housekeeping supervisor or designee will audit 5 rooms 3 days a week for 4 weeks then 1 time a month for 3 months. On 3/25/2019 the pole in resident's room was removed by the Social Worker Designee and	05/01/2019

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F 0921	Continued From page 20 #120 reported Resident #41 would also urinate on the floor and felt the odor was coming from the both the flooring and the resident's mattress. Housekeeping Staff #109 also confirmed the presence of the odor and stated the room was mopped daily. 2. On 03/25/19 at 3:25 P.M. during an interview with Resident #29, a metal rod approximately six feet long was observed propped up against the wall near Resident #29's chair. Resident #29 stated the "pole" was from his bed which had fallen out when staff had fixed the flooring in his room and indicated the pole had been positioned against the wall since then. On 03/25/19 at 3:30 P.M. Social Service Designee (SSD) #112 confirmed the rod/pole was positioned against the resident's wall and indicated it was the part of Resident #29's bed that allowed the head of the bed to raise up and down. SSD #112 stated it could have fallen at any time and should have never been placed there and attempted to proceeded to put the rod back on the bed. 3. On 03/2719 from 8:17 A.M. to 8:30 A.M. and beginning at 10:43 A.M. a tour of the facility with the Administrator and Director of Housekeeping #138 revealed the following environmental concerns which were verified with the Administrator and Director of Housekeeping #138 at the time	F 0921	the resident's bed was replaced. Administrator or designee will monitor residents room for potential hazards 2 times a week for 3 weeks and 1 time a month for 3 months thereafter. Resident 43# bed sheet were changed and laundered after recognized on 3/25/2019 by the facility. Housekeeping supervisor or designee will audit 5 rooms 3 days a week for 4 weeks and 1 time a month for 3 months. Administrator or designee will audit rooms in facility 3 times a week for 4 weeks and 1 time a month for 3 months for environmental issues related to sanitation and safety. Housekeeping supervisor or designee to educate housekeeping staff on proper cleaning routines by 5/1/2019 Maintenance supervisor or designee to educate staff on proper maintenance repair notifications by 5/1/2019. Housekeeping supervisor or designee will ensure that laundry staff is present seven days a week. Housekeeping Supervisor or designee will audit proper staffing levels in department 5 times a week for 4 weeks and 1 time a month for 3 months thereafter. The QA committee will review the monitoring tables to determine the need to continue, change or if compliance has been achieved.	

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F 0921	Continued From page 21 of the observation: A strong odor was noted in Resident #17 and Resident #40 room. The closet door was observed to be leaning against an adjacent wall in Resident #29's room. The closet door was not attached to the closet door frame. Observation of the lid to the toilet tank in the bathroom shared by Resident #1, #15 and #43 was too large and hung over the toilet tank approximately two inches. The closet doors were unable to be securely close in Resident #43, #1, #15, #22, #41, #3 and #24's rooms. One closet door was observed leaning against an adjacent wall in Resident #19 and #26's room. Observation of Resident #43's bedding sheet revealed dark stains were present and the linen was soiled. Observation of the pressure reducing mattress on Resident #41's bed revealed multiple stains on the covering and a strong odor. The Director of Nurses (DON) indicated the mattress needed to be discarded and a new mattress placed on Resident #41 bed. A cable was observed hanging from the ceiling outlet to the floor in Resident #4	F 0921		

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F 0921	Continued From page 22 and #39's room. The walls in the hallway and activity/dining room on the back hall had wall paper partially removed with some wall paper hanging from the wall and numerous gouges noted in the walls. At the time of the observation, State tested nursing assistant (STNA) #120 reported the walls on the secured unit had the wall paper stripped a few weeks ago and the STNA was not sure when the facility was planning on completing the renovation on the unit. STNA #120 confirmed two long pieces of wall paper were hanging from the wall in the dining room above the cabinets. Review of the Maintenance work orders from 01/01/19 through 03/25/19 revealed none of the above concerns had been identified by the facility. On 03/27/19 at 10:04 A.M. Activity Aide #129 reported she worked every Saturday in the housekeeping department at the facility. Activity Aide #129 confirmed on Saturdays she was the only housekeeper on staff and was also responsible for laundry. She stated job duties included sweep and mop rooms, clean common areas, make sure the dining room floors were clean, clean resident bathrooms, change trash, apply toilet paper for resident rooms, make sure floors were swept in the hallway and make sure all linens/towels and essential items were	F 0921		

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F 0921	Continued From page 23 washed and returned to the floor. Activity Aide #129 reported was unable to finish all of these tasks, however focused on sweeping and mopping to keep the floors clean. She indicated resident personal items were only laundered Monday through Friday. Review of facility policy titled Maintenance Policy and Procedure Manual, dated 2019, revealed the philosophy of the facility was to deliver maintenance services. The policy indicated the facility had established a routine maintenance schedule to ensure the facility was in good condition. Review of the undated job description for a Housekeeper revealed the facility was to be maintained in a safe, clean, and comfortable manner. This deficiency substantiates Complaint Number OH00103138.	F 0921		